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Annual Elders Issue

This May issue of THE IHS PROVIDER, published on the occasion of National Older Americans Month, is the sixth annual issue dedicated to our elders. We are grateful for the opportunity to honor our elders with a collection of articles devoted to their health and health care. Indian Health Service, tribal, and urban program professionals are encouraged to submit articles for the May 2002 issue on elders. We are also interested in articles written by Indian elders themselves giving their perspective on health care issues. Inquiries can be addressed to the attention of the editor at the address on the back page of this issue.

White Earth Collaborative Elder Home Fire Safety Project

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Among American Indians and Alaska Natives (AI/AN), the elderly are at higher risk of residential fire/burn mortality (Table 1).[1] The most dramatic increases in mortality rates are in people

Table 1. Residential fire mortality rates by age group, American Indians/Alaska Natives, 1984-1998.*

AGE	0-4	5-14	15-24	25-34	35-44
AI/AN	6.3	1.2	1.6	1.7	2.2
	45-54	55-64	65-74	75-84	85+
	2.3	2.7	4.9	7.3	7.3

**Source: Office of Statistics and Programming National Center for Injury Prevention and Control, CDC. NCHS Mortality Tapes, 1984-1988. Includes all American Indians and Alaska Natives in the United States.*

65 years and older. Among Bemidji Area AI/AN between 1984-1996, the age-adjusted residential fire/burn mortality rate was 8.9

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per 100,000, over six times the US All Races rate of 1.4 per 100,000.[2] During this period, the Bemidji Area AI/AN elder (age 55 and over) residential fire/burn mortality rate of 17 per 100,000 was nearly six times higher than the US All Races elder residential fire/burn mortality rate of 2.9 per 100,000.[2]

Risk factors for fire/burn mortality that may be present in some AI/AN communities include lack of smoke alarms; inoperable smoke alarms; alcohol impairment, especially when smoking; poverty; substandard housing; cold climate; rural location; use of wood stoves; and living in mobile homes.[3,4,5,6,7] In addition, the elderly are at high risk because many have limited mobility, and they may be closer to a fire when it occurs, thus having less time to react.[8]

Approximately 800 elders reside on the White Earth Reservation in Minnesota. Most live in rural areas far from health or fire department services. In January 2000, the White Earth Public Health Nurses, Home Health Aides, Community Health Representatives, and Environmental Health teamed up to form the "White Earth Home Safety Collaborative Team." The Team was formed to complete comprehensive health and safety needs assessment surveys and safety device installation in one-fourth of private elder's homes on the reservation. Environmental Health provided Team members with standardization training in conducting home safety surveys, resident education, and smoke alarm installation.

Photoelectric smoke alarms with 10-year lithium batteries were purchased with injury prevention special project funds from the Bemidji Area Office. Ionization smoke alarms are more commonly installed in homes because they are less costly and more readily available from retail stores. However, ionization smoke alarms are more prone to cooking-related false alarms and subsequent disconnection than photoelectric alarms.[9,10,11,12] This is especially a problem in American Indian communities due to common cooking styles such as deep fat frying, and the small size of homes, which may not allow smoke alarms to be installed an adequate distance from the stove.[12,13]

For two weeks starting in January 2000, the Team surveyed 210 homes. They found that over 50 percent of homes did not have at least one operational smoke alarm, either because one had never been installed, or because installed alarms had been deliberately disconnected, primarily due to false alarms from cooking. The Team installed 240 smoke alarms and provided residents with education on how to maintain and test them. Smoke alarms were installed in homes that never had them, as well as in homes in which smoke alarms were over 10 years old or inoperable (due to a problem with the alarm itself).

Within one week of project completion, the Team was notified of a success story involving an 84-year old elder. The elder stated that he had just finished dinner and fell asleep on his couch. Shortly after falling asleep, he was awakened by the sound of his newly installed smoke alarm. A fire had started when a pan of grease left on the stove ignited. The elder was able to extinguish the fire and save his home. Two existing hard-wired smoke alarms in the home never sounded when the fire started. The White Earth Home Safety Collaborative Team was honored in September 2000 with an Area Director's Award for Outstanding Group Performance (Figure 1).

Figure 1. White Earth Elder Home Safety Collaborative Team

Encouraged by the success of this project and the need for additional smoke alarms for the remainder of the elder private homes, the White Earth Environmental Health Officer successfully wrote a Part 2 IHS Headquarters Injury Prevention Grant. These grants allow tribes to fund full-time injury prevention coordinators (Part 1), special projects (Part 2), and conferences (Part 3). The second phase of this project began in January 2001 with follow-up home surveys conducted on a random sample of 20 percent of homes served during the 2000 White Earth Elder Smoke Detector Project. The preliminary results of this effort reveal that the majority of homes (80%) still have an operating smoke alarm.

A spin-off of this project was the development of a community injury prevention committee. The Injury Prevention Committee was selected to pilot development of "Elder Safe," an American Indian-specific fire and fall safety program funded by the US Fire Administration. In addition to addressing the

need for protecting community elders from residential fire injury with reliable smoke detectors, the Injury Prevention Committee is interested in addressing other elder safety concerns (e.g., fall prevention, carbon monoxide poisoning, and motor vehicle passenger safety).

Acknowledgments

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Adult Day Care as a Viable Eldercare Model for Indian Country

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American Indian and Alaska Native (AI/AN) elders, numbering around 175,000[1] represent a significant segment of the distinctive population of AI/ANs found alongside the larger population. There is a growing crisis in eldercare options for this culturally and geographically diverse people just as there is in the at-large population. However, major divergences in beliefs, health status, history, location, and politics separate the indigenous elder again from those both in the dominant and minority segments of the US populations.

As a nurse in the Santa Fe Indian Hospital for several years, I had clinical contact with elders in New Mexico. It was clear that there was indeed a long term care crisis. The elders (and their families) often used the IHS acute care facility in lieu of structured eldercare on the reservations and Pueblos.[2] Although eldercare options were available in both Santa Fe and Albuquerque, they were not models based on the particular needs and beliefs of the Pueblo, Apache, or Navajo elder. The elders reported that they did not feel they would 'fit in' with programs that were not AI/AN-run.

The author became familiar with the services available in the Albuquerque Area. There were almost no eldercare options designed or located with the AI/AN elder in mind. Two White House Conferences on Indian Aging, hosted by the National Indian Council on Aging (NICOA) in 1992 and 1994, revealed the top priority of Indian elders to be access to long term care.[2] There were available the ubiquitous senior centers with varying capabilities and size (some in shared facilities); two home care agencies, one in its infancy; and the services of one assisted living facility in a southern pueblo. At the time there were no adult day care (ADC) facilities.

For these reasons, hospital discharge options were limited, and the families carried the brunt of the care burden. Although it is reported that 85% of all persons needing long term care receive it from family members nationally, research on aging in an AI/AN population revealed one eldercare model that might be practical and appealing for this population. The adult day care model allows frail elders to remain in the family home during non-operational (evening and nighttime) hours, yet allows families to continue with their daytime routines. This is particularly attractive to both the adult children and the elders.